STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00105519 and IN00106360. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 02/22/12. This visit was in conjunction with a PSR to Complaint IN00104470 completed on 02/29/12. This visit was in conjunction with a PSR to Complaint IN00104877 completed on 03/09/12. Complaint IN00105519 - Substantiated. Federal/State deficiencies related to the allegations are cited at F156, F282, F309, F312, F329, F332, F333 and F514. Complaint IN00106360- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, F226, F309, F327, and F514. Survey dates: April 18, 19, 20, 23, and 26, 2012 Facility number: 010739 Provider number: 155764	F0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AIM number: N/A Survey Team: Regina Sanders, RN, TC (April 18, 19, 20, 23, 2012) Kelly Sizemore, RN Marcia Mital, RN Sheila Sizemore, RN Census bed type: SNF: 46 Residential: 70 Total: 116 Census Payor type: Medicare: 39 Other: 77 Total: 116 Sample: 7 Supplemental sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/04/12 by Suzanne Williams, RN			

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F0156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review and interview, the facility failed to ensure a resident was informed of their rights and the rules and regulations for their responsibility during their stay in the facility in a timely manner, for 1 of 7 residents reviewed for admission records in a total sample of 7 residents. (Resident G) Findings include: Resident G's record was reviewed on 4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. The resident's admission assessment indicated the resident was admitted to the facility on 2/4/12.	F0156	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident G No adverse findings were noted. 2. An audit of current residents admission paperwork in the facility was completed.. No other residents was noted to be affected by this practice. 3. Staff completing admissions will be re- inserviced on assuring admission agreement paper work is completed and signed prior to admission or upon admission. 4. Customer Service Rep(CSR) / designee will conduct daily audits of residents charts assuring admission agreement paper work is completed and signed prior to admission or upon admission. CSR will report findings to QA&A monthly for six months.	05/16/2012

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	The resident's record of admission (face sheet) indicated the resident was admitted to the facility on 2/4/12 at 5:00 p.m. The resident's admission agreement paperwork, which included, the advanced directive, medicare information, the move-in agreement, and resident's rights, were dated 2/6/12. During an interview on 4/19/12 at 10:15 a.m., the Admission staff #2 indicated the paper work should be completed prior to admission or upon admission. She indicated the staff member who had completed the admission paperwork for resident G was no longer employed by the facility. She indicated the admission paper work should not have been done two days after the resident was admitted to the facility. This Federal tag relates to Complaint IN00105519. 3.1-4(a) 3.1-4(f)(1) 3.1-4(f)(1)(A) 3.1-4(f)(1)(B) 3.1-4(f)(2) 3.1-4(f)(3) 3.1-4(j) 3.1-4(j)(1) 3.1-4(l)		5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	3.1-4(j)(3) 3.1-4(j)(2) 3.1-4(f)(4)(A) 3.1-4(f)(4)(B) 3.1-4(g) 3.1-4(h) 3.1-4(k)			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the resident's physician related to the resident frequently pulling an ileostomy bag (bowel movement collection bag on the	F0157	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B who no longer resides in our facility. 2. An audit of the 24 hour reports and residents	05/16/2012

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	abdomen) off her abdomen, resulting in excoriation and irritation to the resident's abdomen, for 1 of 1 resident reviewed for ileostomy care in a total sample of 7. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. A Nurses' Note, dated 03/03/12 at 4 p.m., indicated, "Colostomy (sic) care given x5 (five times) this shift. Res. (resident) cont (continues) to pull off...area around colostomy remains excoriated..." A Nurses' Note, dated 03/04/12 at 11:30 (no a.m. or p.m. documented), indicated, "...excoriation around site remains. Res cont to pull off. changed (triangle) x3..." The Nurses' Notes, dated 03/03/12 and 03/04/12, lacked documentation to indicate the facility notified the resident's physician the resident was continually pulling the ileostomy bag off. Resident #B's Emergency Room physician notes, dated 03/04/12,		current plan of care were reviewed related to status changes and physician notification. No other residents were affected by this practice. 3. Licensed nurses were re-inserviced on notification of physician with status changes that have a potential for requiring a physician intervention. A nurse practitioner has been employed to monitor residents' medical needs and intervene as indicated. 4.The Director of Clinical Health Services (DHS) /designee will conduct audits of daily orders, Change of Condition documentation, 24 hour report and Circumstance charting 5 times per week for six months. DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	indicated, "...Ostomy with surrounding erythema (redness), no induration or fluctuance..." Resident #B's Gastroenterology consult note, dated 03/05/12, indicated, "...she also had excoriation of the ileostomy site due to poor placement of the ileostomy bag the last couple days..." During an interview on 04/19/12 at 2:10 p.m., LPN #3 indicated she had notified the facility's Medical Director only about the excoriation of the area. She indicated she had not documented the physician notification in the resident's record. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00106360. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report an allegation of	F0225	1. Due to the passage of time there is no opportunity to correct the circumstances related to	05/16/2012

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	abuse to the Indiana State Department of Health (ISDH) in a timely manner, for 1 of 2 residents reviewed for abuse in a total sample of 7. (Resident #C) Findings include: During an interview on 4/18/12 at 10:25 a.m., Resident C indicated the staff did not like her and yelled at her. Resident C indicated no one had washed her up, and a staff member had walked out and slammed the door. Review of the investigative reportable incident indicated the facility reported the incident to the Indiana State Department of Health on 4/18/12 at 9:57 p.m. This was 11 hours and 32 minutes after the allegation of abuse was first reported. During an interview on 04/20/12 at 4:20 p.m., the Administrator indicated his understanding regarding reporting was "when you first become aware it is severe in nature, within two hours." This deficiency was cited on 2/29/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00106360.		resident. No adverse findings were noted. 2. Investigations related to allegation of abuse and suspected crimes were reviewed. No other residents were affected by this practice. Ongoing reports of known, suspected, or alleged abuse have been investigated and reported in accordance with guidelines. 3. Staff will be re-inserviced on the facility's policy for Abuse/Elder Justice Act and the procedures for reporting of any allegations of abuse to ensure protection of the residents. 4. The Executive Director will conduct audits of residents' allegations daily to assure that the facility implemented the policy concerning investigation and reported timely any allegation. The Executive Director will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	3.1-28(c)			

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F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. A. Based on record review and interviews, the facility failed to implement the facility's policies for Abuse and the Elder Justice Act and train their employees related to the facility's policies and procedures for protection of the residents, reporting allegations of abuse and suspected crimes under the federal Elder Justice Act and the facility abuse policy, for 8 of 17 employees interviewed. This had the potential to affect 46 of 46 residents who reside in the facility. (Employees #1, #3, #4, #5, #6, #7, #8, and #9) B. Based on record review and interview, the facility failed to develop and implement an abuse policy for timely reporting of allegations of abuse to the Indiana State Department of Health, for 1 of 2 residents reviewed for abuse allegations in a total sample of 7. (Resident #C) Findings include: A. 1. During an interview on 4/18/12 at	F0226	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident. No adverse findings were noted. 2. Investigations related to allegation of abuse and suspected crimes were reviewed. No other residents were affected by this practice. Ongoing reports of known, suspected, or alleged abuse have been investigated and reported in accordance with guidelines. 3. The content of the Trilogy Abuse Policy was reviewed for accuracy and was found to be complete. The staff was inserviced on the definition of immediate to be "as soon as possible" and to not exceed 24 hours. Staff will be re-inserviced on the facility's policy for Abuse/Elder Justice Act and the procedures for reporting of any allegations of abuse to ensure protection of the residents 4. The Executive Director will conduct audits of residents' allegations daily to assure that the facility implemented the policy concerning investigation and reported timely any allegation. The Executive Director will report findings to QA&A monthly for six months. 5. QA&A will monitor	05/16/2012

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	11:50 a.m., CNA #4 indicated she had an inservice on the facility's abuse policy and the Elder Justice Act about one month ago. CNA #4 indicated she could not find the binder at the nurses' station to tell her about what she should do for the Elder Justice Act. CNA #4 could not explain the procedure for calling the Indiana State Department of Health of a suspected crime. CNA#4 was unsure of what procedure she should take if the nurse did not respond. 2. During an interview on 4/18/12 at 11:45 a.m., LPN #3 indicated if she had a staff member suspected of abuse she would send the staff member to work on another unit until she had investigated the allegation. 3. During an interview on 4/18/12 at 12:00 p.m., CNA #5 indicated she had been inserviced on the Elder Justice Act, but could not remember the inservice. 4. During an interview on 4/18/12 at 12:00 p.m., CNA #6 indicated she had been inserviced on the Elder Justice Act, but could not remember the inservice. 5. During an interview on 4/18/12 at 10:15 a.m., RN #7 indicated if she was reporting suspected abuse, she would call the Director of Nursing. RN #7 indicated		monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	155764	A. BUILDING 00 B. WING	04/26/2012

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	she would "call the Administrator if the Director of Nursing wanted her to." 6. During an interview on 4/18/12 at 2:20 p.m., RN #8 (an employee from a sister facility who was helping out at the facility while management staff were at a meeting) indicated she had been inserviced on the Elder Justice Act. RN#8 was unable to indicate who to call or report a suspected crime of abuse to. 7. An interview on 4/18/12 at 11:40 a.m., LPN #9 indicated she did not have the authority to send a suspected staff member of abuse home. LPN #9 indicated she would call the nursing supervisor. RN #9 was unsure of where the Elder Justice Act was posted at in the facility. RN #9 indicated she had been given a pamphlet but was not sure what to do. 8. During an interview on 4/20/12 at 5:15 a.m., LPN #1 indicated she would remove the suspected staff member from the resident's room and ask the resident their side of the story. LPN #1 was unsure of the chain of command of who to go through to report an allegation of abuse. LPN #1 indicated there were no bosses on the midnight shift. During an interview on 4/19/12 at 9:33			

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	a.m., the Clinical Nurse Operations, RN, indicated the nurses have been told they have the authority to send a suspected staff member home. She indicated the nurses are uncomfortable with that and call the Director of Nursing and let her send the suspected staff member home. A facility policy, dated 11/2010, titled "Abuse and Neglect Procedural Guidelines,"indicated "...has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1...has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...b. Training: Provide training for new employees through orientation and with ongoing training programs. Training will include, but is not limited to:...4. How to provide protection for residents...6. How to investigate and report incidents of actual or suspected abuse or neglect...Identification...iv. IMMEDIATELY notify the Executive Director...e. Protection:..iv. Suspend suspected employee(s) pending outcome of investigation...Investigation. i. The Executive Director is accountable for			

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	investigating and reporting...Reporting...ii. 24 hour initial reporting to applicable state agencies...." A facility policy, dated 8/2011, titled "Reporting Crimes Pursuant to the Elder Justice Act," indicated "Purpose: The purpose of this policy is to outline how (name of company) will comply with legal requirements that it notify certain individuals of their duty to report crimes to the Secretary of the Department of Health and Human Services and to local law enforcement...Notification of Duty to Report...c. Serious bodily injury - within two hours...No serious bodily injury - within 24 hours. B. During an interview on 4/18/12 at 10:25 a.m., Resident C indicated the staff did not like her and yelled at her. Resident C indicated no one had washed her up, and a staff member had walked out and slammed the door. Review of the investigative reportable incident indicated the facility reported the incident to the Indiana State Department of Health on 4/18/12 at 9:57 p.m. This was 11 hours and 32 minutes after the allegation of abuse was first reported. During an interview on 04/20/12 at 4:20 p.m., the Administrator indicated his			

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	understanding regarding reporting was "when you first become aware it is severe in nature, within two hours." A facility policy, dated 11/2010, titled "Abuse and Neglect Procedural Guidelines," indicated "...has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1...has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Investigation. i. The Executive Director is accountable for investigating and reporting...Reporting...ii. 24 hour initial reporting to applicable state agencies...." This deficiency was cited on 2/29/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00106360. 3.1-28(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure residents received medications as ordered by the physician for 2 of 7 residents reviewed for following physician's orders in a total sample of 7. (Residents C and G) Findings include: 1. Resident G's record was reviewed on 4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. Resident G's admission physician's orders, dated 2/4/12, indicated an order for Carafate (a stomach medication) 1 gram tablet four times a day. A physician's order, dated 2/4/12, indicated "May give Norco (a pain medication) 7.5/500 mg (milligrams) po (orally) Q (every) 4 hours when Norco 7.5/325 is unavailable." The 2010 Nursing Spectrum Drug Book,	F0282	1. Resident's G and C medication records were reviewed and order clarification were obtained. No adverse findings were noted. 2. An audit of residents' medication records were reviewed. No other residents were affected by this practice. 3. Licensed nurses were re-inserviced on administration of medication in accordance with the physician order, Medication Administration Times Procedures, and documentation required related to medication administration. Medication Pass observations and competencies were completed with nurses. 4. The Director Clinical Health Services/designee will conduct audits of residents' daily physicians orders and MARs five times weekly to assure administration of medication in accordance with Medication Administration Times Procedures, and documentation required related to medication is complete. Follow-up random medication pass observation will be scheduled with nurses. This observation pass will include all shifts three times per week. DHS /designee will report findings to QA&A monthly for six months. 5.	05/16/2012

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	indicated Carafate should be administered one hour before meals and at bedtime. The resident's MAR (medication administration record), dated 2/12, indicated the Carafate was administered at 6 a.m., lunch, dinner, and bedtime. This had been marked through and "rewritten" had been hand written on 2/10/12 after the 6 a.m. dose had been initialed as administered. The resident had received the Carafate on 2/5/12 through 2/9/12 at lunch and supper instead of an hour before the meals. The resident's MAR, dated 2/12, indicated as of 2/10/12, Carafate 1 gram tablet po QID (four times a day) was given at 6 a.m., 11 a.m., 4 p.m., and 9 p.m. (before meals). The resident's controlled drug records, indicated the resident's Norco 7.5/325 milligrams had been received from the pharmacy on 2/5/12, 2/13/12 and 2/22/12. The Norco 7.5/500 milligrams was administered to the resident on 2/6/12 at 12:00 a.m., 2/6/12 at 6 a.m., 2/6/12 at 7 p.m., 2/7/12 at 4 a.m., 2/8/12 at 6 p.m., 2/9/12 at 2:30 a.m., 2/10/12 at 8 a.m., 2/10/12 at 2:15 p.m., 2/11/12 at 10:45 a.m., 2/17/12 at 9:30 p.m., 2/18/12 at 2:30 a.m., 2/20/12 at 8:30 p.m., and 2/21/12 at 7:30 p.m.		QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	During an interview on 4/19/12 at 2;20 p.m., the Corporate Nurse Consultant indicated the nurses should not have given the Norco 7.5/500 milligrams after the Norco 7.5/325 milligrams was delivered from the pharmacy on 2/5/12. She indicated the Carafate should have been given before meals. 2. During an observation on 04/18/12 at 10:25 a.m., Resident #C was sitting in her room and eating breakfast. Resident #C's record was reviewed on 04/19/12 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, and gastroesophageal reflux disease (GERD). A physician's order, dated 04/10/12, indicated, Prevacid (stomach medication) 30 mg (milligrams), one tablet before breakfast. A physician's order, dated 04/11/12, indicated, tramadol (pain medication) 50 mg three times a day before meals. The MAR, dated 04/12, indicated the Prevacid was scheduled to be given, "before breakfast". The MAR indicated the Prevacid was given April 11, 12, 13, 2012 at 9 a.m. and April 14, 15, and 19, 2012 at 10 a.m., and April 16, 17, and 18,			

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	2012 at 8-8:30 a.m. The MAR, dated 04/12, indicated the tramadol was scheduled to be given "before breakfast, before lunch, and before dinner". The MAR indicated the tramadol was given at 10:30 a.m. on 04/18/12 and 10 a.m. on 04/19/12. The MAR then indicated the resident received the tramadol before lunch and before dinner, with no times documented when the medication was given. The meal service schedule, received from the facility, indicated breakfast is from 7 a.m. to 10 a.m., lunch is at 12:15 p.m. and dinner is at 5:15 p.m. During an interview on 04/19/12 at 10:55 a.m., RN #12 indicated Resident #C usually sleeps in until 9 a.m. or 10 a.m. She indicated if the morning medication is given late, she usually tries to give the lunch medication later. She indicated the resident usually eats lunch at 1 p.m. and indicated the tramadol is given close together if given late. During an interview on 04/19/12 at 11 a.m., RN #12 indicated the resident had already been eating breakfast when the tramadol and Prevacid had been given on 04/18/12 and 04/19/12.			

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	An undated policy, titled, "Medication Administration Times Procedural Guidelines", received from the Corporate Nurse Consultant on 04/20/12 at 11:25 a.m., indicated, "...Medications that have been ordered at specific time shall be administered at the time designated by the attending physician..." This deficiency was cited on 02/22/12 and 03/09/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00105519. 3.1-35(g)(2)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and services related to administration of as needed pain medication in a timely manner, assessment of a resident after an emesis, assessment and removal of staples, and assessing residents' pain, for 2 residents in a sample of 7 residents reviewed for receiving the necessary care and services in a total sample of 7 (Residents G and H) and 3 of 7 residents in a supplemental sample of 11. (Residents I, L, and M) Findings include: 1. Resident G's record was reviewed on 4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. A physician's order, dated 2/4/12, indicated "May give Norco (a pain medication) 7.5/500 mg (milligrams) po	F0309	1. Resident's G, H, M, L, and I pain medication records were reviewed and order clarification were obtained. No adverse findings were noted. Due to the passage of time there is no opportunity to correct the circumstances related to resident H emesis and staple removal. No adverse findings were noted. 2. An audit of residents related to current pain status, pain medication orders, change of condition charting, circumstance charting, and physician orders was completed on current residents. No adverse findings were noted. 3.Licensed nurses were re-inserviced on assessing pain, clarification of physician orders, obtaining a physician order, assessment / documentation required with PRN pain mediation administration, required assessment documentation with nursing procedures completed per physician order. Medication Pass observations and competencies were completed with nurses. 4.The Director of Healthcare Services/designee will	05/16/2012

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	(orally) Q (every) 4 hours when Norco 7.5/325 is unavailable." An Admission Minimum Data Set Assessment (MDS), dated 02/11/12, indicated the resident frequently had severe pain (rated at a 6). A care plan, dated 2/22/12, indicated "Pain Acute AEB (as evidenced by) Complaint of pain R/T (related to) Recent surgery...monitor and report to nurse...PRN (as needed) pain medication..." During an interview on 4/18/12 at 2:25 p.m., Resident G indicated she did not get a pain medication one night not too long after she was admitted into the facility, because a CNA did not report to the nurse that she was in pain. She indicated when the nurse came in to check her blood sugar, she told the nurse she was in pain, and the nurse apologized and told her the CNA had not reported to her that the resident was in pain. During an interview on 4/20/12 at 5:27 a.m., LPN #1 indicated she had an incident once, but could not remember the date, when a CNA had not reported to her that a resident was in pain. She indicated the resident had reported to the CNA at about 3 a.m. and she was not aware the		conduct audits of the MARs, daily orders, change of conditions documentation, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Observation will include all shifts three times per week. DHS/designee will report findings monthly to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	resident had pain until 4 a.m. She indicated the CNA no longer worked at the facility. 2. Resident H's record was reviewed on 4/18/12 at 1 p.m. Resident H's diagnoses included, but were not limited to, fractured left hip, hypertension, and arthritis. A) Resident H's admission nursing assessment, dated 3/30/12, indicated the resident had a surgical incision with 15 staples to her left hip The resident's record lacked documentation of a physician's order to remove the staples from the resident's left hip. A skilled nursing assessment, dated 4/6/12, indicated "4/4/12 3 p.m., Incision has 2 staples to well approximated incision..." There was a lack of documentation of an assessment for the removal of the resident's staples or of the incision. During an interview 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant indicated the physician had sent an order over to remove the staples, but they were not able to find the order.			

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	During an interview on 4/20/12 at 8:22 a.m., the Corporate Nurse Consultant indicated the nurse who had removed the staples had missed 2 staples, so another nurse found the 2 staples and removed them. She indicated the nurse who had removed the staples should have counted to be sure she had removed all the staples. She indicated neither nurse had documented an assessment when the staples were removed. B). Resident H's admission physician's orders, dated 3/30/12, indicated Tylenol 500 mg milligrams) every 4 hours as needed for mild to moderate pain and Tramadol (a stronger pain medication) 50 mg every 6 hours as needed for moderate to severe pain. An Admission MDS Assessment, dated 04/06/12, indicated the resident was cognitively impaired and had frequent complaints of moderate amount of pain. The resident's MAR (medication administration record), dated 4/12, indicated the resident had received the as needed Tramadol on 4/1/12, 4/2/12, and 4/15/12. There was a lack of documentation on the back of the MAR to indicate an assessment of the resident's pain had been completed.			

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	The resident's prn medication tracking form, lacked documentation of any documentation of an assessment of the resident's pain for the above dates. There was a lack of documentation in the Nurses' Notes, dated 04/01/12, 04/02/12, and 04/15/12, to indicate the resident's pain had been assessed. During an interview on 4/18/12 at 1:15 p.m., LPN #3 indicated there should have been a pain assessment completed when the resident received the as needed Tramadol. She indicated it should have been documented on the prn form or back of the MAR. C). A change of condition form for resident H, dated 4/2/12, indicated the resident had 2 episodes of emesis at 1:00 p.m. The form indicated the resident's vital signs were taken and the physician had been called. There was a lack of documentation to indicate an assessment of the resident's abdomen and bowel sounds had been completed. The back of the form indicated the follow up on 4/2/12 the 3 p.m.-11 p.m. shift, 4/3/12 the 11 p.m.-7 a.m. shift, the 7 a.m.-3 p.m. shift and the 3 p.m., - 11 p.m. shift, 4/4/12 the 11 p.m.-7 a.m. shift, 7 a.m.-3 p.m. shift, and 3 p.m. - 11 p.m. shift, and			

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	155764	A. BUILDING 00 B. WING	04/26/2012

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	4/5/12 the 7 a.m.- 3 p.m. shift all lacked documentation of any assessments of the residents abdomen or bowel sounds. During an interview on 4/19/12 at 11:40 a.m., LPN #3 indicated if a resident had an emesis the resident should be assessed. She indicated the resident's abdomen should be assessed for bowel sounds and be monitoring for any signs of dehydration. During an interview on 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant indicated as a nurse she would assess the resident's abdomen and bowel sounds if a resident had an emesis. 3. During the medication pass observation, on 4/20/12 at 5:28 a.m., LPN #1 administered medication to resident M. Resident M asked LPN #1 for a pain pill. LPN #1 then went back to the medication cart and removed a Norco 5/325 milligram tablet and administered the medication to the resident. Resident M's record was reviewed on 4/20/12 at 5:43 a.m. Resident M's physician's orders, dated 4/12, indicated the resident had orders for Tylenol 325 milligrams two tablets every four hours as needed for pain and Norco			

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	5/325 milligrams one every four hours as needed for pain. During an interview on 4/20/12 at 5:43 a.m., LPN #1 indicated she had not assessed the resident's pain. She indicated the resident had orders for Tylenol and Norco for pain. She indicated the CNA had reported to her the resident had complained of leg pain earlier. 4. During an interview with Resident L, on 4/19/12 at 9:30 a.m., she indicated sometimes the nurses are late with her prn (as needed) pain medication or they forget. She indicated, "I usually have to ask one more time. I don't ask for them during the day, mostly in the evening or night shift. The night shift you wait the longest. I waited three hours one night about a month ago." The resident was unable to indicate what night she waited three hours. Resident L's record was reviewed on 4/19/12 at 2:40 p.m. Resident L's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and revision of left knee. An Admission MDS (Minimum Data Set) Assessment, dated 1/27/12, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 (cognition			

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	intact, no impairment), had pain frequently which limited day-to-day activities (over the last 5 days), and rated pain an "8," (over the last 5 days, with zero being no pain and ten as the worst pain you can imagine). The CAA (Care Area Assessment) for pain, dated 01/27/12, indicated, "Res (resident) experiencing pain...Res also utilizes PRN pain medication. Res is s/p (status post) L (left) knee surgery. Res also has a diagnosis of arthritis. Res able to make needs known, and will ask for PRN medication if needed..." The Physician recapitulation orders for 3/2012, indicated an order for Norco (pain medication) 10/325 milligram tablet give 1 tablet by mouth every 4 hours as needed for pain. The MAR, dated 03/12, indicated the resident received the Norco multiple times per day, except on 03/17/12 and 03/22/12. 5. Resident I's record was reviewed on 4/19/12 at 2:22 p.m. Resident I's diagnoses included, but were not limited to, fractured ribs, arthritis, and hypertension. A physician's order, dated 4/2/12, indicated Norco (pain medication) 75/325			

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	mg (milligrams) every four hours for pain as necessary. An Admission MDS Assessment, dated 03/19/12, indicated the resident had no cognitive deficits and had no complaints of pain. The April 2012, MAR indicated Resident I received the pain medication twice on 4/4/12 and one time on 4/6/12 and 4/15/12. The backside of the April 2012, MAR was not marked for any as necessary pain medication being administered. Resident I's "PRN Medication Tracking" dated 3/12 and 4/12, was not marked for the medication, date/time, reason for the medication, pain scale, interventions tried before the medication is given, the effectiveness of the mediation and the pain scale after the medication was given for the above dates. The nurses' note, dated 4/2/12, indicated the resident was having "pain occasionally." The nurses' note, dated 4/6/12, indicated the resident was having no pain. The nurses' note, dated 4/15/12, indicated			

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	the resident was not having pain. During an interview on 4/19/12 at 3:14 p.m., RN #12 indicated the resident had not been assessed for the as necessary pain medication. RN #12 indicated she could not find anything to indicate the resident had been assessed for pain. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaints IN00106360 and IN00105519. 3.1-37(a)			

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F0312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to ensure residents who required assistance with bathing received assistance, for 5 of 7 residents reviewed for receiving assistance with bathing in a total sample of 7. (Residents #D, #E, #G, #H, #I) Findings include: 1. During an interview on 04/18/12 at 12:05 p.m., Resident #D indicated she cannot get a shower due to her cast. She indicated the staff do not have time to help her get washed up. She indicated they always say they have someone else to do so she does not get her bedbaths as scheduled. Resident #D's record was reviewed on 04/18/12 at 12:48 p.m. The resident's diagnoses included, but were not limited to, fracture of the right shoulder and wrist and chronic back pain. The resident was admitted into the facility on 03/08/12. The resident's Admission/5 Day Minimum Data Set (MDS) Assessment,	F0312	1. Residents D, E, G, H, and I shower schedule were reviewed and on adverse effects were noted. 2. An audit of residents' shower records were reviewed. No other residents were affected by this practice. 3. Nursing staff were re-inserviced on residents and completion of showers as requested. 4. The DHS/designee will conduct audits of residents' daily shower preference and documentation 5 times weekly to assure showers are completed. DHS will report findings monthly to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	05/16/2012

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	dated 03/15/12, indicated the resident was cognitively intact and required limited assistance with transfers, hygiene, and bathing. The shower schedule, received as current from the MDS Nurse on 04/18/12 at 2:30 p.m., indicated the resident should receive a shower/bedbath on Tuesday and Friday evenings. Review of the resident's bathing chart, dated 03/08/12 through 04/18/12, indicated a bedbath was given on March 15 (seven days without a bedbath) and 16, 2012 and April 1 (11 days without a bedbath), 3, 13 (10 days without a bedbath), and 15, 2012. A shower sheet indicated the resident received a sponge bath with hair wash on 03/20/12. 2. Resident G's record was reviewed on 4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. Resident G was admitted to the facility on 2/4/12. An Admission MDS Assessment, dated 2/11/12, indicated the resident had no cognitive impairment and required			

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	extensive assistance of one staff member for bathing. A care plan, dated 2/22/12, indicated "ADL (activities of daily living) self care deficit...bathing..." The resident's bathing chart indicated the resident had received a shower on 2/10/12, 2/17/12, and 2/25/12. During an interview on 4/18/12 at 2:25 p.m., resident G indicated she did not get showers when she was at the facility. During an interview on 4/20/12 at 10:17 a.m., the Corporate Nurse Consultant indicated she was not able to find where the resident had received any other showers. 3. Resident H's record was reviewed on 4/18/12 at 1 p.m. Resident H's diagnoses included, but were not limited to, fractured left hip, hypertension, and arthritis. The resident had been admitted to the facility on 3/30/12. An Admission MDS Assessment, dated 4/6/12 , indicated the resident had severe cognitive impairment and required extensive assistance of one staff member for bathing.			

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	Review of Health Care 1's shower schedule, provided by the MDS Coordinator on 4/18/12 as current, indicated resident H should receive showers on the day shift on Mondays, Wednesdays, and Fridays. The resident's bathing chart and shower sheets indicated the resident received showers on 4/4/12, 4/6/12, 4/11/12, 4/13/12, and 4/16/12. There was a lack of documentation to indicate the resident had received showers on 4/2/12 and 4/9/12 as scheduled. During an interview on 4/20/12 at 7:50 a.m., the Corporate Nurse Consultant indicated a resident should not wait 5 days after being admitted for a shower. She indicated she was still looking for more shower sheets. 4. Resident E's record was reviewed on 4/19/12 at 3:00 p.m. Resident E's diagnoses included, but were not limited to, dementia, hypertension, and diabetes mellitus. The resident had been readmitted to the facility on 2/29/12 An Admission MDS Assessment, dated 2/12/12, indicated the resident had severe cognitive impairment and required extensive assistance of one staff member			

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	for bathing. A care plan, dated 2/13/12, indicated "ADL self-care deficit...needs assistance or is dependent..." Review of Health Care 1's shower schedule, provided by the MDS coordinator on 4/18/12 as current, indicated Resident E should receive showers on the day shift on Wednesdays and Saturdays. The resident's bathing chart and shower sheets indicated the resident had received showers on 3/7/12, 3/29/12, 4/11/12, 4/14/12, 4/14/12, and 4/18/12. The resident's shower sheet indicated she received a bed bath on 3/19/12. There was no documentation to indicate the resident had received a shower on 3/3/12, 3/10/12, 3/14/12, 3/17/12, 3/21/12, 3/24/12, 3/28/12/ and 3/31/12. During an interview on 4/20/12 at 10:52 a.m., the Corporate Nurse Consultant indicated she was not able to find any other information for showers for the resident. 5. During the Group Meeting with the residents on 4/18/12 beginning at 1:30 p.m., Resident I indicated she had been in the facility three weeks and had only			

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	received 2 showers. Resident I's record was reviewed on 4/19/12 at 2:22 p.m. Resident I's diagnoses included, but were not limited to, fractured ribs, arthritis, and hypertension. The resident was admitted on 3/12/12. Resident I's Admission MDS assessment, dated 3/19/12, indicated Resident I is alert and oriented. The MDS assessment indicated the resident required extensive one staff assist for transfers and bathing. Resident I's shower sheets indicated the resident received her first shower on 3/27/12. This was 15 days after she was admitted on 3/12/12. The resident's "Bathing Type Chart" indicated the resident received her first shower on 4/3/12. The 4/3/12 shower sheet indicated the resident received a bed bath because she had refused a shower. The resident "Bathing Type Chart" indicated the resident received her next shower on 4/5/12. The resident did not receive another shower until 4/11/12. This was 6 days after her last shower. There was no further documentation on			

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	the resident's "Bathing Type Chart." The resident's shower sheets indicated the resident had not received a shower on 4/9/12. The word "no" was handwritten on the shower sheet. The resident's shower sheets indicated the resident's last shower was 4/16/12. During an interview on 4/19/12 at 3:14 p.m., RN #12 indicated she could not find anything more on the resident's showers. During an interview on 4/19/12 at 3:06 p.m., Medical Records indicated she could not find anymore shower sheets for Resident I. An undated facility policy, received from the Nurse Consultant on 4/23/12 at 11:10 a.m., indicated "...6. Bathing shall occur at least twice a week unless the resident preference states otherwise...." This deficiency was cited on 3/9/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00105519. 3.1-38(b)(2)			

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F0327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to provide and assess a resident for sufficient fluid intake, for 1 of 7 residents reviewed for dehydration in a sample of 7. The resident was transferred to the hospital with severe dehydration after only being in the facility five days. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's admission date was 2/29/12, and diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. The admission assessment, dated 02/29/12 at 11:15 a.m., indicated the resident was independent with eating, had no signs or symptoms of dehydration, skin turgor fair, mucous membranes were pink and moist, and was alert and oriented. The admission nutrition care plan, dated 02/29/12, indicated to provide adequate	F0327	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B who no longer resides in our facility. 2. Current residents were assessed related to potential for dehydration and no other residents were affected by this practice. 3. Residents will be assessed related to dehydration potential on admission and with signs and symptoms of dehydration are noted. 4. Staff was re-inserviced on dehydration assessment, documentation of assessment, physician notification and implementation of a preventive interventions. The DHS/designee will conduct audits of new admission dehydration assessment, daily orders, labs, change of condition documentation, and Circumstance charting 5 times per weekly. DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for	05/16/2012

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	hydration. The Skilled Nursing Assessment and Data Collections (daily Nurses' Notes) indicated: 03/01/12 11-7 shift indicated the resident's skin turgor was fair and mucous membranes pink and moist. 03/02/12 3-11 shift indicated the resident's skin turgor was fair and mucous membranes pink and moist. 03/03/12 1:15 a.m. indicated the resident's skin turgor was fair and mucous membranes pink and moist. 03/04/12 11-7 shift indicated the resident's skin turgor was fair and mucous membranes pink and moist. The Nurses' Notes, dated 03/03/12 at 4 p.m., indicated, "Res (resident) c/o (complains of) not eating. Was given hot dog & shake & chips. Was served supper also..." The Nurses' Notes, dated 03/04/12 at 11:30 a.m., indicated, "...c/o nausea...family in and wanting Res sent to ER...Family insistent Res be sent out..." The resident's fluid intake records indicated the following total fluid intakes: 03/01/12-340 cc's (cubic centimeters) 03/02/12-220 cc's 03/03/12-200 cc's		any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	03/04/12-660 cc's An ambulance transfer record, dated 03/04/12 at 1:18 p.m., indicated, "...pt (patient) is c/o (complaints) nausea, poor appetite, & poor oral intake for approximately a week. Pt's skin is tenting (poor turgor noted)..." Resident #B's Emergency Room physician notes, dated 03/04/12, indicated, "... Positive for nausea, vomiting and abdominal pain...oriented to person, place, and time...BUN (kidney test) 84 (normal 7-21) Creatinine (kidney function) 3.64 (normal 0.50-1.20) Calcium 6.3 (Normal 8.5-10.5) Sodium 126 (normal 135-145) Potassium 5.7 (normal 3.4-5.3) Chloride 80 (Normal 97-108)..." Resident #B's Gastroenterology consult note, dated 03/05/12, indicated, "...At the nursing home, the patient has been quite nauseous frequently...The last few days she has been getting dehydrated and feeling lightheaded...At the time of presentation to the Emergency Room, the patient was clearly significantly dehydrated..." A physician consult, dated 03/06/12, indicated, "...Within a five day period of time, she became very lightheaded and			

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	155764	A. BUILDING 00 B. WING	04/26/2012

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	dehydrated and was readmitted to (hospital name)..." During an interview on 04/19/12 at 2:10 p.m., LPN #3 indicated the family wanted the resident sent to the hospital due to nausea. She indicated the resident had not vomited. During an interview on 04/20/12 at 9 a.m., the Regional Vice President indicated the facility had found no other intake records. She indicated she could not comment on the resident's liquid intake because she did not know if the resident took other fluids during the day and the staff had not recorded it. This Federal tag relates to Complaint IN00106360. 3.1-46(b)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interview, the facility failed to monitor a resident's apical pulse when administering digoxin (a cardiac medication) during 1 of 8 medication passes for 1 resident in a supplemental sample of 11. (Resident J) Findings include: 1. During a medication pass on 4/20/12 at 6:02 a.m., LPN #1 was observed administering medications to Resident J. LPN #1 was observed administering	F0329	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident J. No adverse findings were noted. 2. All current residents medication records were reviewed and no other residents were affected by this practice. 3. Licensed nurses were re-inserviced on assessment and documentation required with administration of a medication. Medication Pass observations and competencies were completed with nurses. 4. The DHS/designee will conduct audits	05/16/2012

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	digoxin 250 mcg (micrograms) tablet to Resident J. LPN #1 was not observed taking an apical pulse for 1 minute prior to the administration of the digoxin. During an interview on 4/20/12 at 7:45 a.m., LPN #1 indicated she should have checked the resident's apical pulse prior to the administration of the digoxin. During an interview on 4/20/12 at 7:50 a.m., the Corporate Nurse Consultant indicated an apical pulse should be taken with the administration of digoxin. The 2010 Nursing Spectrum Drug Book, indicated "digoxin...Patient monitoring Assess apical pulse regularly for 1 full minute..." This deficiency was cited on 02/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00105519. 3.1-48(a)(3)		of daily orders, MARs documentation, change of condition, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Random medication pass observation will include all three shifts three times per week. The DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to remain free of medication error rate of 5 percent or greater related to giving a medication before a meal when the physician had ordered the medication to be given with meals, and failing to give enough liquid with a medication for constipation and administering medications for cholesterol(Lipitor) in the morning and heart medication (digoxin) not given at the ordered time for 2 residents in a supplemental sample of 11 (Residents J and K), during the observation of 2 of 8 medication passes. A total of 52 opportunities for error were observed. A total of 4 medication errors were observed. This resulted in a medication error rate of 7.69% Findings include: 1. During a medication pass on 4/19/12 at 11:04 a.m., LPN #15 was observed administering Asacol (a medication for ulcerative colitis) 400 milligrams 3 tablets to Resident K. Resident K's record was reviewed on	F0332	1. Due to the passage of time there is no opportunity to correct the circumstances related to residents J and K. No adverse findings were noted. 2. All current residents medication records were reviewed and no other residents were affected by this practice. 3. Licensed nurses were re-inserviced on assessment and documentation required with administration of a medication. Medication Pass observations and competencies were completed with nurses. The Nurses were re-inserviced on the 5 rights of medication administration and the facility medication pass times. 4. The DHS/designee will conduct audits of daily orders, MARs documentation, change of condition, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Random medication pass observation will include all three shifts three times per week. The DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits	05/16/2012

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	4/19/12 at 11:18 a.m. The resident's physician's orders, dated 3/19/12, indicated the Asacol 1200 milligrams was to be given three times a day with meals. During an interview on 4/19/12 at 11:21 a.m., LPN #15 indicated the resident would be having lunch around noon. She indicated she had an hour before or an hour after the medication was scheduled to be given. She indicated even if the medication was ordered to be given with a meal, she still had an hour before or after scheduled time to give the medication. 2. During a medication pass on 4/20/12 at 6:02 a.m., LPN #1 was observed administering medications to Resident J. LPN #1 was observed preparing Miralax powder, she poured the cap full of medication into a 4 ounce plastic glass. The label on the bottle of the Miralax powder indicated to mix 17 grams (1 capful) in 8 ounces of liquid. LPN #1 indicated she thought the glass was an 8 ounce glass. LPN #1 was also observed administering Lipitor 80 (statin medication for high cholesterol) milligram tablet and digoxin (a cardiac medication) 250 mcg tablet to resident J.		until 100% compliance is achieved.	

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	Resident J's record was reviewed on 4/20/12 at 7:15 a.m. Resident J's physician's orders, dated 4/11/12, indicated Lipitor 80 milligrams one tablet orally every day upon rising, digoxin 250 mcg one tablet orally every day at 8 p.m., and Miralax 17 g (grams) orally every day as needed for constipation. During an interview on 4/20/12 at 7:45 a.m., LPN #1 indicated the glass she used for the Miralax was only a 4 ounce glass. The 2010 Nursing Spectrum Drug Book, indicated Lipitor and digoxin as a drug-drug interaction. When given with digoxin, Lipitor increases the level and causes a greater risk for toxicity of the digoxin. During an interview on 4/23/12 at 1:55 p.m., the Regional Vice President indicated she had called the facility's pharmacist who indicated the medications of Lipitor and digoxin should never be administered at the same time. She indicated the pharmacist had told her the medications should never be administered together; there should be at least 8 hours between the medication times. She indicated a statin (Lipitor) medication over 10 milligrams and Digoxin should			

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	not be given together, period. During an interview on 4/26/12 at 8:45 a.m., with the Clinical Operation Support RN and the facility's pharmacist, the pharmacist indicated the medication of Lipitor should be administered at bed time. He indicated the dose of 80 milligrams or higher of Lipitor would have to be closely monitored for elevated serum digoxin levels. He indicated this was a moderate level and could increase the digoxin blood levels 10%. This Federal tag relates to Complaint IN00105519. 3.1-25(b)(9) 3.1-48(c)(1)			

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F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free of a significant medication error, related to an omitted dose of Lanoxin (heart medication) for 1 of 7 residents reviewed for significant medication errors in a total sample of 7. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was admitted into the facility on 02/29/12 at 11:15 a.m. from the hospital. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. A physician consult, dated 03/06/12, indicated, "...At the time of her discharge...She had all of her medications spelled out, but apparently after she got there, they did not have her medications..." The transfer medication orders from the hospital, dated 02/29/12, included an order for Lanoxin 0.125 mg (milligrams)	F0333	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B. No adverse findings were noted. 2. All current residents medication records were reviewed and no other resident were affected by this practice. 3. Licensed nurses were re-inserviced on assessment and documentation required with administration, and holding of a medication. Medication Passes were completed with nurses. 4. The DHS/designee will conduct audits of daily orders, MARs documentation, change of condition, and Circumstance charting 5 times weekly. Follow-up random medication pass observation will be scheduled with nurses. The medication observation will include all three shifts three times per week. The DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	05/16/2012

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	daily. The medication administration record, dated 03/12, indicated by circled initials, the resident did not receive her Lanoxin on 03/01/12. The back of the MAR lacked documentation to indicate why the resident had not received the Lanoxin. During an interview on 04/20/12 at 6:35 a.m., the Regional Vice President indicated all the medications were given but the Lanoxin. She indicated the facility could not show where the Lanoxin had been given. Review of the 2010 Nursing Spectrum Drug Handbook, indicated for Lanoxin, "...take drug at same time every day. Instruct patient not to stop drug abruptly..." This deficiency was cited on 02/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaint IN00105519. 3.1-25(b)(9) 3.1-48(c)(2)			

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F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure medical records where complete and accurate related to, physician notification, admission care plans, documentation of medication times, and physician's orders for 4 of 7 residents reviewed for medical records in a total sample of 7, (Residents #B, #C, #F, and #H) Findings include: 1. Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. A) A Nurses' Note, dated 03/03/12 at 4 p.m., indicated, "...area around colostomy (sic) remains excoriated."	F0514	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B.. Residents C, F, and H physician notification, admission care plans, documentation of, medication times, and physician orders were reviewed. No adverse effects were noted at this time 2. An audit of residents' medication record, physician notification, care plans and documentation of medication times were reviewed. No other residents were affected by this practice. 3. Licensed Nurses were re-inserviced on physician notification, admission care plans, documentation of medication times and obtaining physician order for treatments rendered.	05/16/2012

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	A Nurses' Note, dated 03/04/12 at 11:30 (no a.m. or p.m. documented), indicated, "...excoriation around site remains..." The Nurses' Notes, dated 03/03/12 and 03/04/12, lacked documentation to indicate the facility notified the resident's physician about the excoriation around the resident's ileostomy. During an interview on 04/19/12 at 2:10 p.m., LPN #3 indicated she had attempted to notify the resident's physician, but the physician had not returned the call to the facility, so she notified the Medical Director and he said to just monitor the area. She indicated she did not write the notification in the resident's record. She indicated she did not put the area on a non-pressure skin sheet. B) Resident #B's admission nursing assessment, dated 02/29/12 at 11:15 a.m., indicated the resident had a colostomy for elimination. The elimination care plan on the admission assessment was left blank. During an interview with the admitting nurse on 04/20/12 at 8 a.m., LPN #10 indicated the ileostomy had not been marked on the admission sheet and there was no care plan for the ileostomy.		4. The DHS/designee will conduct audits of admission care plans, daily orders, MARs documentation, change of condition, and Circumstance charting 5 times weekly. DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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	An undated policy, titled, "Documentation Time Frames", received from the Regional Vice President on 04/20/12 at 10:10 a.m., indicated, "The following list of documentation time frames are the minimum requirements...Entry...Initial Assessment Initial Care Plan..." 2. Resident #C's record was reviewed on 04/19/12 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, and gastroesophageal reflux disease (GERD). A physician's order, dated 04/11/12, indicated, tramadol (pain medication) 50 mg three times a day before meals. The MAR, dated 04/12, indicated the tramadol was scheduled to be given "before breakfast, before lunch, and before dinner." The MAR then indicated the resident received the tramadol before lunch and before dinner, with no times documented when the medication was given. During an interview on 04/19/12 at 10:55 a.m., RN #12 indicated if the morning medication is given late, she usually tries to give the lunch medication later. An undated policy, titled, "Medication			

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	Administration Times Procedural Guidelines", received from the Corporate Nurse Consultant on 04/20/12 at 11:25 a.m., indicated, "...The nurse administering the medications shall record the time the medication was administered along with his/her initials. a. The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together..."			
	3. Resident F's record was reviewed on 4/18/12 at 12:10 p.m. Resident F's diagnoses included, but were not limited to, traumatic brain injury, seizures, and dysphagia. Nurse's notes, on 3/11/12 at 12:30 a.m., indicated "This writer entered resident room to find PEG (feeding tube) tube in his hand..." Nurse's notes, on 3/11/12 at 12:35 a.m., indicated "Foley cath (urinary catheter) inserted into ostomy (opening in stomach from feeding tube) to maintain patency. MD notified et (and) rec'd (received) orders to send to ER for tx (treatment)." The physician's orders lacked an order for the foley catheter to be inserted into the ostomy. During an interview with the Regional			

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	Vice President on 4/19/12 at 2:05 p.m., she indicated there was nothing in the chart pertaining to putting in a foley catheter when the resident pulled out the peg tube. During an interview with the RN Nurse Consultant on 4/19/12 at 2:30 p.m., she indicated she spoke with the nurse who was working that night. The nurse indicated she spoke with the doctor about it but she didn't write the order. 4. Resident H's record was reviewed on 4/18/12 at 1 p.m. Resident H's diagnoses included, but were not limited to, fractured left hip, hypertension, and arthritis. Resident H's admission nursing assessment, dated 3/30/12, indicated the resident had a surgical incision with 15 staples to her left hip The resident's record lacked documentation of a physician's order to remove the staples from the resident's left hip. A skilled nursing assessment, dated 4/6/12, indicated "4/4/12 3 p.m., Incision has 2 staples to well approximated incision..." There was a lack of documentation of the removal of the resident's staples or of the incision.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant indicated the physician had sent an order over to remove the staples, but they were not able to find the order. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This Federal tag relates to Complaints IN00106360 and IN00105519. 3.1-50(a)(1) 3.1-50(a)(2)			